Exhibit 9: Sample Individualized Healthcare Plan (IHP)

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

SAMPLE INDIVIDUALIZED HEALTH CARE PLAN (IHCP)
HEALTH CARE PLAN FOR THE SCHOOL SETTING

_____ (Health Care Coordinator)

_____ (Education Coordinator)

Student Information:

_____ (Name) _____ (Birthdate)

_____ (Grade)

_____ (School)

_____ (Parent/Guardian) _____ (Address)

Mother (___) _____ (home) (___) _____ (work)

Father (___) _____ (home) (___) _____ (work)

Preparation for Entry/Development of Health Care Plan

❒ Home Assessment _____ (Date) by _____ (Name, Title)

Summary _____ (Date) Parent Interview _____ (Date)

Student Interview _____ (when appropriate) (Date)

❒ Medical History _____ (Date)

❒ Planning Meetings _____ (Date) _____ (Date) _____ (Date)

❒ Staff Training Meetings _____ (Date) _____ (Date) _____ (Date)

❒ Educ. Team Meeting _____ (Date) _____ (Date) _____ (Date)

Doctor's Order _____ (Date) Child-Specific Care-giver Training (Skills Checklist) _____ (Date)

Parent's Consent _____ (Date) Next Training Review _____ (Date)

Child-Specific Procedural Guidelines _____ (Date) Health Care Plan Included in IEP: _____ (Date)

Emergency Plan _____ (Date) Next Review of Health Care Plan _____ (Date)

Health Care Plan Included in Child's Record _____ (Date)

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PLANNING CHECKLIST FOR IHCP AND IEP DEVELOPMENT
For Students with Special Health Care Needs

FAMILY
❒ Goals/priorities
❒ Liaison
❒ Collaboration
❒ Communications
❒ Other

HEALTH SERVICES
❒ Health assessment, including student strengths
❒ Individualized health care plan
❒ Emergency plans
❒ Health status monitoring
❒ Specialized health procedure
❒ Health teaching/counseling
❒ Medication
❒ Personnel training
❒ Personnel supervision
❒ Staff consultation
❒ Family support/liaison
❒ Physician consultation/orders
❒ Parent authorization(s)
❒ Release of info to/from health care provider
❒ Other

TRANSPORTATION
❒ Vehicle
❒ Access
❒ Safety
❒ Equipment
❒ Positioning
❒ Emergency plan
❒ Communications
❒ Special assistance
❒ Evacuation
❒ Aide
❒ Other

TUTORING/HOME/HOSPITAL
❒ Supplemental in-school tutor — regular, intermittent
❒ Plan for continuous programming — school/home/hospital
❒ Extra set of books at home
❒ Regular home/hospital program
❒ Other

OTHER PROGRAM ADAPTATIONS
❒ Curriculum/instruction
❒ Special equipment
❒ Activities of daily living
❒ Scheduling of health interventions
❒ Positioning
❒ Mobility
❒ Special diet
❒ Other

ACCESS
❒ School entrance
❒ Hallways
❒ Stairs/elevator
❒ Classroom/specials
❒ Bathroom
❒ Health room
❒ Cafeteria
❒ Library
❒ Locker
❒ Gym
❒ Playground
❒ Other

FIRE SAFETY
❒ Evacuation plan
❒ Evacuation practice
❒ Back-up plan
❒ Other

SCHEDULING
❒ Length of day
❒ Number of days
❒ Rest periods
❒ Flexible schedule
❒ Testing schedule
❒ Other

THERAPIES
❒ Occupational therapy
❒ Physical therapy
❒ Speech language pathology
❒ Other

OTHER RELATED SERVICES
❒ Social work
❒ Counseling
❒ Psychology
❒ Other

EXTRACURRICULAR ACTIVITIES
❒ Special learning opportunities
❒ Extended day program
❒ Clubs
❒ Sports
❒ Social events
❒ Transportation
❒ Access
❒ Other

FIELD TRIPS
❒ Medication plan
❒ Emergency plan
❒ Personnel
❒ Transportation
❒ Other

nal version of this checklist was published by the Federation for Children with Special Needs as "Checklist of items for consideration ping IEPs for students with physical disabilities or special health needs." This adaptation appeared, with permission, in *Serving with Special Health Care Needs*, Connecticut State Department of Education, 1992. It is used here with the permission of both sources.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

KEY CONTACTS

Name_____ Date_____

Primary Health Care Providers	Telephone Numbers

School Contacts

	Training	
Direct Caregivers	Child-Specific	General
Substitute Caregivers		
Back-up Staff		

Child-Specific Training Done By

_____ _____
(Date)

General Staff Training Done By

_____ _____
(Date)

Supervision Provided By

_____ _____
(Frequency)

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BACKGROUND INFORMATION

Name_____ Date_____

Brief Medical History:

Home Assessment Summary:

Special Health Care Needs of the Child:

Baseline Status:

Medication:

Diet:

Transportation Needs:

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CHILDREN WITH SPECIAL HEALTH CARE NEEDS

PLAN FOR SPECIFIC PROCEDURE

Name _____ Date _____

Procedure: _____

Frequency: _____ Times: _____

Position of student during procedure: _____

Ability of the student to assist/perform procedure: _____

_____

Suggested setting for procedure: _____

Equipment:

Daily: _____ Emergency: _____

Checked by: _____ Checked by: _____

Storage: _____ Storage: _____

Maintenance: _____ Maintenance: _____

Home Care Co.: _____ Phone: _____

Child-specific techniques and helpful hints:

_____

Special considerations and precautions:

_____

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DAILY LOG FOR PROCEDURES

Name _____ School _____

Procedures _____

Parent _____ Phone _____

Date/Time	Procedure Notes	Observations	Name of Provider

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CHILDREN WITH SPECIAL HEALTH CARE NEEDS

LICENSED PROVIDER'S ORDER
FOR SPECIALIZED HEALTH CARE PROCEDURE

Student's Name: _____ Birthdate: _____

Address: _____

Procedure: _____

_____

❒ I have reviewed the Health Care Plan and approve of it as written.

❒ I have reviewed the Health Care Plan and approve of it with the attached amendments.

❒ I do not approve of the Health Care Plan. A substitute plan is attached.

Other recommendations:

_____

_____

_____

_____

_____

_____

_____

Duration of the Procedure:

_____

(Date)

Physician's Signature: _____

Date: _____

Address: _____

_____ Phone: _____

[Adapted with permission from: *Pupil Personnel Services. Recommended Practices and Procedures Manual.* Illinois State Board of Education. 1983.]

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PARENT AUTHORIZATION FOR SPECIALIZED HEALTH CARE

We (I), the undersigned, who are the parents/guardians of

_____ _____

(Name) (Birthdate)

request that the following health care service(s)

_____

_____

be administered to our child. We understand that a qualified designated person(s) will be performing the above- mentioned health care service. It is our understanding that in performing this service, the designated person(s) will be using a standardized procedure which has been approved by our physician.

_____

(Physician's Name) (Address) (Phone)

We will notify the school immediately if the health status of_____ changes, we change physicians, or there is a change or cancellation of the procedure.

We understand that the above procedure should be scheduled before or after school hours whenever possible.

Signature of
parents/guardians_____

_____

Address:

_____

_____

Phone: (Home) _____(Work) _____

_____ _____

Date:

_____

[Adapted with permission from: *Pupil Personnel Services. Recommended Practices and Procedures Manual.* Illinois State Board of Education. 1983.]

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CHILDREN WITH SPECIAL HEALTH CARE NEEDS

POSSIBLE PROBLEMS

Name _____ Date_____

Observation	Reason	Action

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EMERGENCY INFORMATION

Name: _____ Birthdate: _____

Address: _____ Telephone: _____

_____

Mother: _____ Work: _____ Home: _____

Father: _____ Work: _____ Home: _____

Guardian: _____ Work: _____ Home: _____

Other contact: _____ Phone: _____

Emergency Numbers:

EMT: _____ Telephone: _____

Fire: _____ Telephone: _____

Police: _____ Telephone: _____

Home Care Co.: _____ Telephone: _____

Ambulance: _____ Telephone: _____

Gas Co.: _____ Telephone: _____

Electric: _____ Telephone: _____

Preferred Hospital:

_____ Telephone: _____

Local Hospital Emergency Room:

_____ Telephone: _____

Primary Physician: _____ Telephone: _____

Dentist: _____ Telephone: _____

Specialists:

_____ Telephone: _____

_____ Telephone: _____

_____ Telephone: _____

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CHILDREN WITH SPECIAL HEALTH CARE NEEDS

EMERGENCY PLAN

Name:_____ Date:_____

Child-Specific Emergencies:

If You See This	Do This

If an emergency occurs:

1. Stay with the child.
2. Call or designate someone to call the nurse.

   State who you are:

   State where you are:

   State problem:

3. The school nurse will assess the child and decide whether the emergency plan should be implemented.
4. If the school nurse is unavailable, the following staff members are trained to deal with an emergency and to initiate the emergency plan:

   _____

   _____

   _____

   _____

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EMERGENCY TELEPHONE PROCEDURE

Name: _____

1. Dial 911 and/or designated ambulance company.
2. State who you are: "I am _____, a nurse/teacher/ para-professional in the

   _____ school."
3. State where you are:

   School name: _____

   Address: _____

   City: _____
4. State what is wrong with the child.
5. Give specific directions (e.g., which school entrance should be used, location of child).
6. Don't hang up. Ask for the information to be repeated and provide any other necessary information. Hang up when all information has been received and is correct.
7. Notify:

   a. School principal or school official in charge of the building at that time

   _____

   b. School back-up personnel _____

   State:

   "Emergency plan for _____ is in effect."

   "The student is located _____."
8. The school official will:

   a. Meet the EMTs.

   b. Direct EMTs to the emergency area.

   c. Call parents and other necessary individuals (including primary care provider).

An adult should be designated to accompany the child in the ambulance.

Hospital that the child should be transported to: _____

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Source: Massachusetts Department of Public Health. (1995). *The Comprehensive School Health Manual, pp. 7-27 through 7*